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EVALUATION OF EPSDT PROGRAMS IN THE TAPE-TO-TAPE STATES

VOLUME I: SYNTHESIS OF EPSDT CASE STUDY REPORTS

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I. Overview of the Objectives and Structure of the EPSDT Evaluation: Process Analysis Component

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program was established in 1967 as the pediatric component of the Medicaid program. The goal of the program is to periodically screen Medicaid-enrolled children throughout their development, up to 21 years of age, in order to detect correctable conditions early and, in turn, provide appropriate treatment services.

Since its inception, however, the program's success in screening and treating eligible children has fallen short of policymakers', program officials' and advocates' expectations for a variety of complex reasons. These include insufficient outreach, inadequate provider participation, and variable coverage across the states of both screening and treatment services. To address these shortfalls, Congress included several provisions in the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) designed to increase the proportion of children screened, broaden provider participation, and expand benefit coverage, among other enhancements.

In 1992, the Health Care Financing Administration (HCFA) awarded a three-year contract to SysteMetrics, a Division of the MEDSTAT Group and its subcontractor, Health Systems Research, Inc. (HSR), to evaluate the impact of OBRA-89 on the performance of the EPSDT program. Specifically, HCFA asked the evaluators to measure OBRA-89's impact in the four "Tape-to-Tape" states--California, Georgia, Michigan and Tennessee--for which uniform research files have been constructed from Medicaid eligibility and claims data.

The EPSDT evaluation includes both outcomes and process analysis components; HSR is responsible for the process analysis. Per the contract scope of work, the process analysis entailed conducting site visits to the four study states during the first project year and, based on the findings of the site visits, developing detailed case study reports. The qualitative knowledge gained through the case studies regarding how the states operate their EPSDT programs and, in particular, how program policies changed as a result of the OBRA-89 legislation provide the project with critical insights into the factors that contribute to states' successes and/or failures related to EPSDT. In addition, the narratives allow the research team to more fully understand and accurately interpret the outcomes and implications of the various quantitative analyses being conducted under other aspects of this evaluation.

This final report presents the results of HSR's process and is organized into two volumes, as described below:

- ***Volume I***, a synthesis of the process evaluation findings, presents an overview of the structure and timing of the site visits, background on the EPSDT program and OBRA-89, a summary of the study states' responses to OBRA-89, and a discussion of OBRA-89's overall impact and future challenges facing the EPSDT program.

- ***Volume II*** presents the four individual case study reports on the EPSDT programs in California, Georgia, Michigan, and Tennessee and analyzes the impact that OBRA-89 has had on each of these state's programs. An introduction to the case

study reports, including an overview of how these reports are organized, may be found in the Guide to Volume II presented at the beginning of the document.

A. Structure and Timing of the Site Visits

This report is based on findings from site visits conducted between April and August 1993. Each site visit was led by Ian Hill, Associate Director of HSR, who was accompanied on two of the visits by HSR Policy Associate Beth Zimmerman and, in all cases, by a member of the SysteMetrics research team. SysteMetrics staff were included on the site visit to maximize the potential for integrating the outcomes and process analyses. The visits, each lasting between four and five days, were organized as follows:

- On the first day of each visit, the evaluation team met with key state officials responsible for administering various aspects of the EPSDT program, including Medicaid, Maternal and Child Health, and Social Service administrators.

- In order to learn how operations vary across local service delivery systems, the remaining time during each visit was spent conducting visits and interviews in diverse localities, including large urban cities, medium-sized towns, and rural communities. During these visits, meetings were held with local officials such as city/county health administrators, federally-funded Community Health Center directors, physician and nursing providers, and social services staff.

The visits were conducted according to the schedule shown in Table I-1 below.

Interviewers used two structured, comprehensive protocols--the first targeted to state officials and the second to local officials and providers--to obtain consistent information across sites. Specific topics explored during the interviews included:

- Informing, enrollment, and outreach activities;

- Provider participation in EPSDT, including the delivery of preventive care outside the EPSDT system;

- Policies regarding EPSDT screens, including periodicity schedules, lead screening, and immunizations;

- Diagnostic and treatment services;

- State reporting of EPSDT participation data; and

- Special initiatives to integrate EPSDT with managed care, early intervention and school-based health services.

In all cases, discussions addressed whether, and how, policies and procedures in these areas had changed in response to OBRA-89.

Table I-1.
SITE VISIT SCHEDULE.

State	Localities	Site Visit Team	Date
Tennessee	Nashville/Davidson County Memphis/Shelby County Perry County Tipton County	Ian Hill Marilyn Ellwood	April 1993
Michigan	Detroit Ingham County Bay County	Ian Hill Lisa Herz	May 1993
Georgia	Fulton County Bibb County Lowndes County Plains	Ian Hill Beth Zimmerman Norma Gavin	June 1993
California	Sacramento County Alameda County Contra Costa County Merced County	Ian Hill Beth Zimmerman Kathleen Adams	August 1993

B. Structure of Volume I

The remainder of Volume I is divided into four major sections, as follows:

- *Section II* provides background information on how EPSDT programs generally operate in the study states, including descriptions of informing and outreach strategies, the content and delivery of EPSDT screening examinations, providers who render EPSDT screens, and the delivery of diagnostic and treatment services.

- *Section III* describes the provisions of OBRA-89 that were designed to enhance the capacity of the EPSDT program to serve eligible children. The specific provisions discussed include those to: increase the proportion of eligible children that receive screening services; ensure an adequate supply of Medicaid providers; enhance the scope and availability of EPSDT screens; and improve the linkages between screening exams and needed diagnosis and treatment services.

- *Section IV* summarizes the study states' responses to the provisions contained in OBRA-89.

- *Section V* concludes Volume I by summarizing the overall impact of OBRA-89 in the four study states and discussing major issues and challenges facing the EPSDT program in the future.

II. Background on State EPSDT Programs

To provide a context for discussion of OBRA-89 provisions and the study states' responses to them, this section provides a brief overview of how EPSDT programs generally operate in the four study states: California, Georgia, Michigan, and Tennessee. Four major program areas are discussed below: informing and outreach; the EPSDT screen; screening providers; and the delivery of diagnostic and treatment services.

A. Informing and Outreach

The Medicaid statute requires that all families be informed about the availability of EPSDT benefits as they become eligible for Medicaid. While all states must fulfill this informing requirement, the statute provides them considerable flexibility in designing the processes through which families are told about EPSDT and/or linked to its services.

Generally, families with eligible children are initially told about EPSDT during the Medicaid enrollment process. The social service worker verbally explains the free benefits that can be obtained through the EPSDT program and the importance of preventive care, and may also provide the family with written material such as a brochure. Then, the parent is usually asked whether they would like their child (or children) to participate in EPSDT and whether they need assistance in finding a provider or arranging transportation.

Unfortunately, EPSDT informing typically receives very little emphasis during the overall Medicaid eligibility process; eligibility interviews can take several hours and often include assessments of not only eligibility for Medicaid, but for AFDC, Food Stamps, and other related programs, as well. Examples provided during the site visits describing the approaches to informing used in the study states highlight this point:

- ***Tennessee's*** 12-minute informational video to introduce persons applying for assistance to the various available social service programs devotes only 30 seconds to the EPSDT program;

- In ***Michigan***, just five minutes of the average one-hour interview is typically spent discussing EPSDT; and

- In *Georgia*, it was reported that the question asking families if they would like to participate in EPSDT is asked on page 24 of a 26-page AFDC/Medicaid application.

In most states, efforts to enroll families in EPSDT are limited to those conducted during the eligibility interview described above. However, in the early 1990s, approximately one-third of states nationwide engaged in additional outreach activities, typically in conjunction with state and/or local public health departments (Hill and Breyel, 1991; National Governors' Association, 1992). Interestingly, all four states in this evaluation involve local health departments in additional outreach activities beyond the informing provided during the Medicaid eligibility process. Although variations exist across the study states, outreach strategies typically include sending letters and/or placing phone calls to families to inform them of the importance of EPSDT screens and to offer assistance with finding providers and arranging transportation. In only a limited number of sites were resources reported to be sufficient to allow for home visits to be routinely conducted, although public health officials across the study states described home visits as the most effective means of engaging families.

As indicated above, all four study states conduct additional outreach to new enrollees beyond the informing provided during the Medicaid eligibility process. In three of these states (Georgia, Michigan, and Tennessee), all eligible children are targeted for additional contact, although resource limitations have required health departments to focus their efforts on certain subsets of the population (typically infants and young children). In California, however, additional outreach is explicitly limited only to families who express an interest in the program during the Medicaid eligibility interview.

B. The EPSDT Screen

The key principle behind the EPSDT program is the provision of comprehensive, periodic well-child exams, referred to as "screens." By providing children with periodic screening examinations, the EPSDT program is designed to detect problems early and, therefore, avoid preventable illnesses.

As defined in Medicaid regulations,[1] a comprehensive EPSDT screen must include the following components:

- A comprehensive health and developmental history (including evaluation of both physical and mental health development);
- A comprehensive unclothed physical exam;
- Immunizations appropriate to age and health history;

[1] Social Security Act, 42 U.S.C. § 1396d(r) (Supp V 1993).

- Laboratory tests, including (since OBRA-89) blood lead level assessment appropriate to age and risk;
- Health education, including anticipatory guidance;
- Vision services, including eyeglasses;
- Dental services, including both preventive and restorative services; and
- Hearing services, including hearing aids.

Screens are to be provided at appropriate age-based intervals, according to the state's periodicity schedule. For the study period 1989-1992, the American Academy of Pediatrics (AAP) recommended that every child obtain a total of 20 visits from birth to age 21, distributed as follows: six well-child visits between birth and 12 months; three visits between one and two years; three visits between three and five years; two visits between six and eight years; and six visits between nine and 20 years. In three of the four study states, the periodicity schedules in effect in 1989 differed from the schedule recommended by the AAP. By 1992, one of these states--Michigan--had increased the number of recommended screens to comply with the AAP standards, bringing the number of study states in compliance with AAP recommendations to two (see Tables I-2 and I-3).

Table I-2.
AMERICAN ACADEMY OF PEDIATRICS WELL-CHILD VISIT AND STATE-SPECIFIC EPSDT SCREENING VISIT SCHEDULES, 1989.

	Number of Recommended Visits				
Age Range	**California**	**Georgia**	**Michigan**	**Tennessee**	**AAP**
Birth to 12 months	6	6	3	6	6
1-2 years	3	3	3	3	3
3-5 years	2	3	3	3	3
6-8 years	3	1	1	2	2
9-20 years	3	6	6	3	6
Total	15	20	12	15	20

Table I-3.
AMERICAN ACADEMY OF PEDIATRICS WELL-CHILD VISIT AND STATE-SPECIFIC EPSDT SCREENING VISIT SCHEDULES, 1992.

Age Range	Number of Recommended Visits				
	California	Georgia	Michigan	Tennessee	AAP
Birth to 12 months	6	6*	6*	6	6*
1-2 years	3	3	3	3	3
3-5 years	2	3	3	3	3
6-8 years	1	2	2	2	2
9-20 years	3	6	6	4	6
Total	15	20	20	18	20

* One additional visit was added for newborns discharged within 24 hours or less after delivery.

C. Screening Providers

In all states, EPSDT screens are typically rendered by a mix of public and private providers. In the four states included in this study, two distinct models of EPSDT service delivery emerged: one dominated by local health department providers (Georgia and Michigan), and one dominated by private physicians (California and Tennessee). Even in California and Tennessee, however, where 80 percent of EPSDT-enrolled providers are private physicians, state officials noted that these providers perform only about 50 percent of all EPSDT examinations. The remainder are provided by a mix of local health department and federally-funded Community and Migrant Health Center providers.

In characterizing the EPSDT provider pool, it is important to keep in mind that, while physicians perform the bulk of screens in private settings, mid-level providers under physician supervision typically provide screening examinations in public clinics. Depending on the state, mid-level providers who may render and bill for EPSDT screens include physicians' assistants, nurse practitioners, nurse midwives, and, in some cases, registered nurses with additional training in physical assessment skills.

D. Delivery of Diagnostic and Treatment Services

As indicated above, the major tenet of the EPSDT program is to conduct periodic examinations to detect problems early and avoid, or limit the impact of, preventable illnesses. In order to achieve this goal, children identified as having a health problem through an EPSDT screen must have timely access to needed diagnostic and treatment services. Traditionally, however, EPSDT has succeeded better as a screening program than as a treatment program (Hill and Breyel, 1991). To explore the degree of need for, and the adequacy of delivering, diagnosis and treatment services in the study states, the researchers explored with providers two major areas: the proportion of children receiving EPSDT screens that are found to have health problems and the overall availability of specialty providers.

On average, providers in the study states reported that 50 percent of children screened are identified as having a health problem needing attention. The ailments most commonly detected include such common childhood problems as otitis media, skin rashes, and respiratory infections. Dental problems among children were also widespread in the four study states, and developmental, behavioral, and nutritional problems were noted in several states as being more commonly found among Medicaid children.

Depending on the training and capacity of the provider, many of these health problems are immediately treated by the screening provider. For more complicated cases, referrals are made to outside providers. Generally, access to specialists in the study states was described as quite good. Exceptions to this rule noted by individuals interviewed during the site visit included a scarcity of dental and mental health providers for children needing follow-up care.

III. EPSDT Provisions of the Omnibus Budget Reconciliation Act of 1989

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) contained several important provisions intended to enhance the capacity of the EPSDT program to serve eligible children.[2] Specifically, these provisions aimed to: improve states' performance in screening high proportions of eligible children; increase provider participation; enhance the comprehensiveness of screening services; and improve coverage of diagnostic and treatment services. Key OBRA-89 provisions are described below.

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[2] Following on the heels of several laws that gave states increased flexibility to expand Medicaid income eligibility thresholds for pregnant women and children, OBRA-89 required states to cover pregnant women and children up to age six with incomes below 133 percent of the federal poverty level and also to phase in coverage of children up to age 19 living below the federal poverty level by the year 2001.

A. Participation Goals

In an effort to increase the proportion of eligible children that receive screening services, OBRA-89 required the federal government to establish for state Medicaid programs annual EPSDT participation goals. In response to this requirement, the Department of Health and Human Services (DHHS) established an 80 percent participation target for all states to reach by 1995, with state-specific intermediate goals for the intervening years between 1990 and 1995. In fiscal year 1989, the average state screened 39 percent of all Medicaid-enrolled children (HCFA, 1990). By fiscal year 1992, this average figure had dropped to 36 percent, even farther from the 80 percent target set by DHHS for 1995 (HCFA, 1993).

While this provision emphasized the importance of providing children with EPSDT screens, it failed to acknowledge the fact that Medicaid-enrolled children do receive preventive care outside of EPSDT, in so-called "shadow" EPSDT programs. Therefore, while EPSDT participation rates describe the percentage of children for whom EPSDT screens are billed, they undercount the number of Medicaid-enrolled children who receive well-child examinations--billed as preventive office visits--from other Medicaid-participating physicians.

B. Provider Participation

The OBRA-89 legislation focused states' attention on ensuring an adequate supply of Medicaid providers for mothers and children. Specifically, the law's "equal access" provision requires states to annually demonstrate to HCFA that the fees they pay to obstetric and pediatric providers are sufficient to enroll enough providers so that Medicaid enrollees have access to services to the same extent as the general population. Through this amendment, OBRA-89 broadly addressed the problem of inadequate physician participation in Medicaid. It did not, however, directly address insufficient physician participation in states' EPSDT programs, a problem commonly reported by states.

C. The EPSDT Screen

There were four OBRA-89 provisions that affected policies related to the EPSDT screen. Specifically, the provisions addressed partial screening, lead screening, periodicity schedules, and interperiodic screens, as described below.

- ***Partial screens and partial screening providers.*** In an attempt to increase the number and types of providers that can render EPSDT screening services, OBRA-89 prohibited states from limiting the pool of EPSDT providers to only those who can deliver the entire range of screening services. Thus, the law implied that states must allow "partial" screening providers--those who can deliver just one, or a few of, the EPSDT screen components--to participate in the program.

- ***Lead screening.*** OBRA-89 required that the comprehensive EPSDT screen include blood lead level testing, appropriate to age and risk, as well as health education regarding lead poisoning.

- ***Periodicity schedules.*** OBRA-89 required states to develop distinct periodicity schedules for screening, vision, hearing, and dental services.

- ***Interperiodic screens.*** OBRA-89 specified that screening exams which are medically necessary to identify and treat health problems must be covered, even if their timing does not coincide with the intervals outlined in a state's periodicity schedule.

D. Diagnosis and Treatment Services

Another OBRA-89 provision was designed to improve children's access to needed follow-up care after the screening examination. The law specifically required states to cover *any* services potentially coverable under Medicaid that are necessary to treat a condition identified during a screen, whether or not they are already included as benefits in a state's Medicaid plan.

IV. State Responses to OBRA-89

During the site visits, the evaluation teams gained a detailed understanding of how the four study states responded to the OBRA-89 EPSDT provisions described above. A summary of these responses appears below.

A. Participation Goals

The 80 percent EPSDT participation target was established by DHHS to stimulate states to develop strategies to increase the proportion of children who receive EPSDT screens. This directive did not, however, carry with it any specific guidance regarding how states should alter the way they administer their EPSDT programs. Based on information gathered during the site visit, one particular program area that appears to have received increased attention from states as a result of this participation target is EPSDT outreach. Among the study states, vivid examples of efforts to rethink how, and by whom, outreach services are delivered were noted,[3] including:

- In *Michigan*, the Medicaid agency has begun distributing monthly outreach reports to managed care providers under contract with the state, while also diverting a portion of its outreach budget from the local health departments to health maintenance organizations, to support HMO-based outreach activities.

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[3] These policy changes were under development during the end of the study period. Therefore, the impact of these strategies will not be measurable in the quantitative analyses.

- Following the examples of Pennsylvania and Louisiana, the Medicaid agencies in both ***Georgia*** and ***Michigan*** are moving to contract out portions of the EPSDT outreach function to private firms with the goal of improving effectiveness and efficiency.

Despite renewed focus on outreach by several of the study states, the EPSDT participation rates reported to HCFA by California, Georgia, Michigan, and Tennessee indicate that the 80 percent target remains a distant, and perhaps unattainable, goal. Ironically, even though the total number of screens performed by the study states nearly doubled between 1989 and 1992--from 1.12 million to 2.19 million--the actual EPSDT participation rates dropped dramatically (HCFA, 1990, 1993). As displayed in Table I-3, EPSDT participation rates in the study states dropped between 11 percent (in Tennessee) and 50 percent (in Michigan) between 1989 and 1992. These declines can be primarily attributed to continued eligibility expansions for children over the evaluation study period which resulted in significant increases in the base number of children eligible for EPSDT.

Table I-3.
EPSDT PARTICIPATION RATES AND PERCENT DECLINES, 1989 AND 1992.

State	1989	1992	Percent Change
California	63%	36%	-42.9%
Georgia	44%	23%	-47.7%
Michigan	48%	24%	-50.0%
Tennessee	27%	24%	-11.1%

Source: HCFA, 1989, 1992.

A second program area in which policies were significantly changed with the goal of improving EPSDT screening rates was provider participation. As will be described below, expanding the pool of providers participating in EPSDT was viewed by the four study states as a key strategy for improving children's access to the program.

B. Provider Participation

As indicated above, OBRA-89 included an "equal access" amendment to address the broad issue of physician participation in Medicaid. It did not, however, include any provisions specifically addressing provider participation in EPSDT other than allowing partial screening providers. Despite this, the study states implemented several notable strategies to increase the base of providers participating in EPSDT after the passage of OBRA-89. These included:

- *Tennessee* hired a full-time medical consultant in late 1992 who designed a number of administrative improvements to enhance provider recruitment and retention. These included: simplifying billing for EPSDT by reducing paperwork; developing age-appropriate check-off sheets for EPSDT exams to assist physicians with documentation; making the Medicaid/EPSDT provider manual more user friendly; and conducting direct provider recruitment.[4]

- In September 1990, *Michigan* opened the doors of its EPSDT program to all private physicians by instituting a two-tiered EPSDT system. Under the new arrangements, screens provided by existing, certified EPSDT providers (mainly local health departments) were counted as "comprehensive" screens, while preventive well-child exams provided by other Medicaid-enrolled physicians were reclassified as "basic" EPSDT screens. Furthermore, a higher fee was established for comprehensive screens than for basic screens. These changes were made only after lengthy debate and analysis of the content of physician-provided well-child exams.[5]

- While implemented well before OBRA-89, *California's* Child Health and Disability Prevention (CHDP)[6] local administrative units have retained their key role in provider recruitment over the years. County CHDP administrative units facilitate the participation of private physicians in EPSDT by assisting providers in billing and by keeping them up to date on program policy changes.

- Since late 1991, *Georgia* has worked hard to recruit schools as EPSDT providers. To facilitate schools' ability to provide screening services, the state has established a program to train registered nurses to conduct EPSDT screens and, concurrently, broadened Medicaid policy to include registered nurses who have completed this training as certified EPSDT providers. Other strategies undertaken by the state to improve overall physician participation in EPSDT include streamlining the claims submission and reimbursement process and working with the Georgia chapter of the American Academy of Pediatrics to develop a recruitment video and conduct other physician education efforts.

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4 Unfortunately, as the medical consultant was only hired in late 1992, these strategies were not in effect during the evaluation study period.

5 To alleviate quality concerns of public health officials, Medicaid issued with this change a detailed physician manual revision specifying the components required to be included in an EPSDT exam and laying out the periodicity schedule that should be followed in providing children with preventive check-ups. In addition, through its schedule of fees, the program maintained financial incentives to reward physicians for obtaining certification as "comprehensive" providers.

6 California's EPSDT program is known as the Child Health and Disability Prevention program. In addition to financing screening services for Medicaid-eligible children with state and federal funds, CHDP supports state-funded screens for children through age eighteen with incomes up to 200 percent of the federal poverty level who are found to be ineligible for Medicaid.

C. The EPSDT Screen

As indicated above, OBRA-89's provisions related to the EPSDT screen were intended to permit the provision of partial screens, enhance the content of the screening examination, and ensure consistency with recommended periodicity schedules. The study states' responses to each of these provisions are described below.

1. Partial Screens and Partial Screening Providers

OBRA-89's provision regarding partial screens and partial screening providers has generated a significant amount of controversy nationally. In particular, Medicaid officials have been reluctant to implement this provision, despite its positive intent of broadening the base of screening providers, for two main reasons:

- First, many components of the screening exam, such as vision and hearing tests and immunizations, can already be provided, and billed for, separate from the comprehensive exam; and
- Second, and most important, many program officials and policy analysts believe that allowing providers to deliver just a portion of the EPSDT screening examination will increase the fragmentation of care and, furthermore, undermine states' efforts to provide all children with a medical home.[7]

Based on this reasoning, none of the states in this evaluation changed their policies to allow either partial screens or partial screening providers. Although several of the study states reported receiving calls from audiologists, psychologists and other therapy providers asking to enroll as partial screeners after passage of OBRA-89, officials generally denied these requests based on the argument that the services these providers rendered were already available through Medicaid outside of the EPSDT program. California is the only study state that recognizes partial EPSDT screens;[8] however, this policy was in effect prior to passage of OBRA-89.

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[7] HCFA officials have publicly expressed these concerns, as well. In fact, in October 1993, HCFA issued a Notice of Proposed Rule Making that would authorize states to require that one provider render all medical components of the screening exam (everything but vision, hearing, and dental services).

[8] Under California's "partial screening" policy, providers may bill the CHDP program for procedures (e.g., vision and hearing exams, immunizations) that for some reason could not be provided during a prior screening examination. However, providers are only permitted to bill for partial screens for children who have had a claim submitted for a prior CHDP exam.

2. Lead Screening Policies

OBRA-89's provision requiring lead screening to be included in the comprehensive EPSDT screen had little or no effect in the study states, until recently. While all of the study states covered lead screening prior to OBRA-89, in three of the study states (Georgia, Michigan, and Tennessee) protocols were generally not well defined and providers rarely included lead screening as part of the comprehensive screening examination. However, in 1991, the Centers for Disease Control (CDC) issued guidelines, which have since been adopted by HCFA, that specified the frequency and type of lead testing that should be done. Through adoption of CDC's recommendations, the states have since significantly upgraded their lead screening policies. For example, at the time of the site visits, all four states required that a blood lead test, rather then the less sensitive erythrocyte protoporphyrin (EP) test, be performed for the initial lead screening as recommended by the CDC.

Despite the implementation of stricter lead screening policies at the state level, interviews with state and local officials and providers indicated that important implementation issues remain at the local level. For example:

- Many providers do not view lead poisoning as problematic in their areas;
- Pediatricians are resistant to performing the venipuncture procedure which is often recommended for obtaining blood samples for lead screening, as they believe it is much more painful than the capillary "fingerstick" method and because of the difficulty of performing the procedure; and
- Providers are concerned that there is insufficient availability of treatment and environmental abatement services for children identified as having elevated blood lead levels.

In contrast to the other three study states, California was actively engaged in facilitating and promoting lead screening long before passage of OBRA-89. The state has reimbursed providers for lead testing when medically indicated since 1983 and, over the years, has publicized the problem of childhood lead poisoning and encouraged pediatricians to screen children. California has also facilitated the development of an extensive network of laboratories proficient in lead testing. These strategies have helped to expand lead testing in the state; according to state officials, approximately 15,000 lead screens are conducted each month.[9] However, officials indicated that there remains a great need for better targeting of efforts and resources, particularly to Hispanic and Asian children who are at high risk for lead poisoning due to their more likely exposure to ceramics and folk medicines containing lead.

[9] This figure is still a small portion of total enrollees.

3. Periodicity Schedules

OBRA-89's requirement that states have distinct periodicity schedules for screening, vision, hearing, and dental services has generated little response in the study states. During the site visits, Medicaid officials indicated that this is because their programs were already essentially in compliance with the law. For example, while three of the study states (Georgia, Michigan and Tennessee) reported not actually having four distinct periodicity schedules, officials in these states believe that their combined periodicity schedules for several of the specified service categories, or policies which cover services whenever medically necessary, are in line with OBRA-89's intent.

Certain changes to the periodicity schedules were made, however, in response to the law in two of the study states:

- ***California*** developed a distinct periodicity schedule for dental services to complement those already in place prior to passage of the law for screening, vision, and hearing services. In addition, the state took the extra step of adding recommendations for lead testing to the screening periodicity schedule.

- ***Michigan*** increased the total number of screens recommended throughout childhood and adolescence from 12 to 20 to reflect the recommendations of the American Academy of Pediatrics.

4. Interperiodic Screens

OBRA-89's requirement that Medicaid pay for "interperiodic screens" also generated a limited response in the study states. In two of the study states, California and Michigan, interperiodic screens were already covered prior to OBRA-89. However, their policies regarding when providers were reimbursed for such screens were quite restrictive. After passage of the new law, Michigan removed its requirement that claims be reviewed for medical necessity. California, however, still maintains its medical necessity review before reimbursing screens falling outside of the state's periodicity schedule. Tennessee, which did not pay for interperiodic screens prior to OBRA-89, responded to the law by instituting a new medical necessity trigger when claims for screens in excess of the state's periodicity schedule are submitted.

Like California and Michigan, Georgia had paid for medically necessary interperiodic screens prior to OBRA-89, although these visits were considered diagnostic and treatment services rather than "screens." In response to OBRA-89, Georgia formally changed its EPSDT policy to allow reimbursement for one additional complete screen before any scheduled exam in the periodicity schedule, as long as the second visit is medically necessary and completed by a different provider than the previous exam.

D. Diagnosis and Treatment

National surveys of Medicaid and Maternal and Child Health programs conducted since 1990 have revealed that very few states have enacted significant policy changes in response to OBRA-89's requirement that Medicaid cover any diagnosis or treatment services needed by a child to address a condition identified during a screen (Hill and Breyel, 1991; National Governors' Association, 1992). The site visits revealed this pattern to hold true in the states included in this evaluation. In all four of the study states, Medicaid officials indicated that they believed that their programs' coverage of services was very broad and that they did not need to make major changes to the depth and breadth of coverage of children's services. In response to the law, however, all four Medicaid programs have instituted a medical necessity review process to assess, on a case-by-case basis, whether services beyond those covered by the state plan are needed to treat eligible children.

Beyond this, however, and not directly in response to OBRA-89, two of the four study states have recently developed enhanced service programs for children:[10]

- In February 1993, Michigan implemented the Infant Support Services program which provides enhanced support and developmental benefits for high-risk newborns, including: psychosocial and nutritional assessment; professional interventions by a multi-disciplinary team of social workers, nutritionists, nurses, and infant mental health specialists; care coordination; parenting education; and transportation.

- In April 1993, Georgia established the Children's Intervention Services Program (CISP) which covers therapeutic services for Medicaid-eligible children who have also been determined to be eligible for the state's Part H early intervention program. Services provided through CISP include audiology, nursing, nutrition, occupational therapy, physical therapy, social work, speech-language pathology and developmental therapy instruction.

V. Summary and Issues for the Future

This section provides a summary of OBRA-89's impact in the four study states and concludes with a discussion of future challenges facing the EPSDT program as identified by the study.

A. Summary of the Impact of OBRA-89

Based on the information gathered during the evaluation site visits, OBRA-89's impact on state EPSDT programs has been paradoxical. On the one hand, as indicated by the above discussion, the four study states implemented very few policy and program changes in response to the individual

[10] Once again, the examples provided occurred outside of the study period.

provisions of OBRA-89. On the other hand, interviews with state and local officials indicated that the visibility of EPSDT and the emphasis policymakers have placed upon improving the program's reach and effectiveness have significantly increased since passage of the law. In particular, the 80 percent participation goal seems to have produced the most impetus for states' increased attention to their EPSDT programs, as evidenced by efforts to raise persistently low screening rates through enhanced outreach, implementation of strategies to expand provider participation, and--as in Michigan--new ways of counting EPSDT visits.

In many cases, the study states' lack of action in response to certain provisions of OBRA-89 seems quite justified, given program officials' interpretations of the law relative to their own states' EPSDT programs. For example:

- Although only minimal changes were made in states' coverage of diagnosis and treatment services over the evaluation period, most of the study states already had very broad coverage of Medicaid's optional services before passage of OBRA-89.

- The three study states did not institute distinct periodicity schedules for screening vision, hearing, and dental services nonetheless meet the spirit of OBRA-89 because they have combined periodicity schedules for several of the specified service categories.

- The reluctance of the states to create partial screening service and provider categories in order to avoid breaking up the core medical screen is in line with their ongoing efforts to reduce fragmentation of care and provide all children with a medical home.

In other respects, however, the study states' unresponsiveness to OBRA-89 represents a failure to take advantage of potential opportunities to improve service delivery systems for children, as illustrated by the following examples:

- Providers who were interviewed for this study often reported that they were unaware of any policy or procedural changes to cover all medically necessary services for conditions discovered during an EPSDT screen, thus revealing states' inadequate efforts to inform providers of this key OBRA-89 change.

- Interviews with providers also indicated their continued reluctance to perform interperiodic screens due to their belief that states would not reimburse for these screens, again pointing to states' limited efforts to inform providers of changes in the law.

- While states' reluctance to use the partial screening provision out of a fear of fragmenting the core medical screen seems on target, it is unfortunate that none of the states have used this opportunity to increase the provision of certain components of the EPSDT exam that are appropriately provided independently. For example, designers of the legislation have reported that part of the intent of this provision was to provide states with the flexibility to design creative strategies for expanding the

delivery of certain services that are often neglected (Rosenbaum, 1994). The partial screen provision could, for example, be used to create an EPSDT-based funding stream to support widespread delivery of preventive dental exams or community-based lead screening campaigns.

- Finally, states have only just begun to implement strategies to address the serious problem of lead poisoning among children.

Overall, however, the site visitors found significant evidence that the study states place a higher priority on improving EPSDT's effectiveness than they did before 1989. Further, state officials now commonly speak of incorporating EPSDT principles for quality preventive care into broader systems reforms and managed care initiatives. In many cases, new efforts to expand the EPSDT provider base and enhance outreach have been either directly or indirectly inspired by OBRA-89.

B. Future Challenges Facing EPSDT

Taken together, the process analyses conducted in the four Tape-to-Tape states provide important insights into critical issues facing the EPSDT program in the future. The changing nature of health care financing and delivery systems, resulting in large part from the proliferation of managed care arrangements and other reform initiatives, present important challenges to states striving to improve the delivery of services to low-income children.

Several specific areas where policymakers will need to refocus their attention if they are to continue to improve children's health are described below. These include: enhancing public investment in outreach; expanding the definition of appropriate and necessary care; and ensuring a continued, if different, role for EPSDT.

1. Enhancing Public Investment in Outreach

Across the four study states, state and local officials as well as providers stressed the critical role of outreach in promoting appropriate use of EPSDT. In Michigan, this point was vividly illustrated when, in October 1991 in response to statewide budget difficulties, the Department of Social Services eliminated funding for outreach in local health departments for a nine-month period. During this time, state officials reported that the number of screens performed across the state dropped by 30 percent.

Despite the widely-held belief in the importance of outreach, however, funding for outreach remains one of the most tenuous components of EPSDT. As demonstrated in the above example, funding for outreach is often an easy target for state budget cuts. Even when funding for outreach has been kept constant, rapid increases in the number of children eligible for EPSDT have seriously affected the ability of states to perform effective outreach. In Georgia, for example, large increases in enrolled children without corresponding increases in Medicaid-funded outreach positions was indicated by states officials to have increased the staff-to-client ratio from approximately 1:3,000 to 1:8,800 between 1985 and 1992.

Furthermore, site visits confirmed numerous negative consequences of limited resources for outreach, including:

- Older children are rarely targeted for outreach efforts, given that priority is typically placed on infants and preschool children;
- Local outreach agencies rely mainly on letters and phone calls to notify clients of the importance of EPSDT and pending appointments rather than on home visits, although home visiting is consistently acknowledged as the most effective means of conducting outreach; and
- Limited availability of, and funding for, transportation services commonly limits outreach workers' ability to facilitate children's receipt of services.

Whereas public health and MCH staff consistently expressed the desire for more fiscal and staff resources to bolster their outreach efforts, Medicaid officials have tended to instead explore alternative approaches, such as contracting out selected outreach functions to private firms. While these strategies may provide a much-needed fresh focus on outreach, their heavy reliance on telephone-based strategies, rather than more intensive home visiting, raises concerns that hard-to-reach populations may not be successfully brought into care through these approaches.

2. Expanding the Definition of Appropriate and Necessary Care

Service coverage under Medicaid is clearly very generous. Compared to most private health insurance policies, Medicaid covers a much broader range of benefits, including the preventive care that is often excluded from standard indemnity plans. Furthermore, since passage of OBRA-89, states are required to cover any service a Medicaid-eligible child needs to treat a condition discovered during an EPSDT screening examination, a stipulation unparalleled in the world of private health insurance coverage. Despite broad coverage of medical services, however, certain critical access gaps persist. In particular, access to dental care was found to be severely limited in all four study states, despite being a central component of the EPSDT program.

Furthermore, even while Medicaid coverage of children's medical services is broad, the benefit package often still falls short of covering many of the psychosocial support services that low-income, high-risk children need for proper growth and development. Most states have recognized the importance of enhanced services for high-risk pregnant women and have adopted Medicaid coverage of such support services as case management, psychosocial and nutritional counseling, health education, and home visiting (Hill, 1992; National Governors' Association, 1990, 1992). However, most states have not added coverage of such services for children. Although Michigan and Georgia have recently moved to cover support services for certain populations of children, they are among the few states in the nation that have done so (Hill and Breyel, 1991; National Governors' Association, 1992). To increase the access of children at psychosocial risk to enhanced services and, thus, improve their potential for positive growth and development, states will need to reconsider what types of services constitute "appropriate and necessary" care for low-income children, just as they have for pregnant women.

3. Integrating EPSDT into Mainstream Medical Practice

Since its inception in the late 1960s, EPSDT has been marketed and operated as a special and distinct component of the Medicaid program. This unique identity has helped the EPSDT program to succeed in focusing special attention on children and on the importance of preventive and primary care. In rare cases, it has also encouraged provider participation; in California, for instance, the use of local CHDP/EPSDT administrative units and a billing system separate from, and more efficient than, that for the state's general Medicaid program were credited during the site visits as key factors in providers' acceptance of the program.

In many ways, however, EPSDT's distinct identity has hindered its integration with mainstream medicine and, therefore, the program's long-term success. EPSDT's separate administrative structure largely accounts for these problems. For example, providers are often required to undergo a separate enrollment process from that for the general Medicaid program in order to participate and, furthermore, must often complete a separate documentation and billing form to be paid for conducting a screening examination. These requirements are cumbersome for providers and, importantly, are not easily integrated into systems evolving under managed care.

States are increasingly relying on managed care systems to contain rapidly escalating Medicaid costs and to improve access to care. The rise of managed care as the primary vehicle for financing and delivering health care services to both publicly- and privately-insured persons has important implications for the EPSDT program. In particular, although public health departments have traditionally played a major role in the delivery of EPSDT screens in many states, their role in direct service delivery is likely to decrease significantly over the coming years as Medicaid recipients are increasingly linked with private-based primary care physicians. But while public health departments' role in screening children may diminish, it seems likely that their role in conducting outreach will remain. In fact, the growth of managed care offers new opportunities for partnerships between public and private systems of care. For example, public health nurses could help managed care providers by contacting families and encouraging them to obtain preventive care and other needed services.

Given this anticipated shift of screening activities to the private sector, the evaluators explored differences in the delivery of screening services between public health nurses and private physicians. Interviewees in all four states indicated that there are important differences in the practices of these two provider types. For example, as compared to screens rendered in private physician's offices, screens delivered in local health departments are more likely to: be delivered by a non-physician provider such as a physician assistant or nurse practitioner; include more vigorous diagnostic assessments such as the pure tone audiometer hearing test and Denver Developmental Exam; and take longer to execute (45-60 minutes as compared to approximately 30 minutes by private physicians), with the extra time taken in local health departments to fully explain test results, provide more comprehensive health education, and discuss nutrition and other health and social problems that the family may be experiencing.

While, to some degree, these observed differences cause public health officials to worry that children seen in physicians' offices are not receiving screens of optimal quality, Medicaid and

public health officials at both the state and local levels in the study states were generally quite satisfied that the overall quality of care rendered by both public and private providers is high.[11] Furthermore, the benefits derived when a child has a true medical home, and is therefore seen consistently for both well and sick care by the same physician, are believed to significantly outweigh concerns about these differences. Following the lead of Michigan, therefore, it is reasonable to consider eliminating the distinction between EPSDT and other forms of Medicaid-financed preventive care. Such integration would paint a more accurate, and positive, picture regarding the portion of Medicaid-enrolled children who are receiving preventive care.

Today, establishing and monitoring standards for the delivery of high-quality care in the evolving health care system is one of the most critical challenges facing reformers. Given the proliferation of managed care arrangements, for which few monitoring tools have been developed and about which concerns regarding financial incentives to underserve patients are great, the need for vigorous quality standards is particularly pressing. Perhaps, therefore, the most promising role for EPSDT in a reformed health care system is not as a distinct program for a select population of low-income children. Rather, by incorporating the quality standards so long embraced by the program into mainstream medical practice and, for example, into contracts with managed care providers, EPSDT can become the accepted gold standard for the delivery of pediatric preventive care for all children.

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[11] Under the outcomes portion of the evaluation, the quantity of preventive care visits made by Medicaid children were also studied and compared to that of other children in the United States. The analysis found that, when all preventive care visits are considered--including EPSDT screening visits, Medicaid-covered non-EPSDT preventive care visits, and preventive care visits not covered by Medicaid--Medicaid children made roughly the same percentage of visits recommended by the American Academy of Pediatrics in 1987 as did children with private insurance coverage. See N. Gavin, E. Herz, K. Sredl, and D. Bencio. *Are Medicaid children receiving adequate levels of preventive care?* Paper presented at the 11th Annual Meeting of the Association for Health Services Research, San Diego, CA, June 13, 1994.

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Rosenbaum, Sara. Personal communication during the August 2, 1994 meeting of the project's Technical Advisory Panel.

Appendix A

Site Visit Agendas

I. California

August 2-6 , 1993

Monday, August 2, 1993

8:30 - 10:30 a.m.	Child Health and Disability Prevention Program
10:30 a.m. - 12:00 p.m.	Part H Program, Department of Developmental Services
1:00 - 2:00 p.m.	Medi-Cal Managed Care Division, Medical Care Services Program
2:00 - 4:00 p.m.	Medi-Cal Policy Division, Medical Care Services Program
4:00 - 5:00 p.m.	Medi-Cal Operations, Medical Care Services Program

Tuesday, August 3, 1993

8:30 - 3:00 p.m.	Sacramento County Health Department Provider visits with the Molina Medical Center and Dr. Gilbert Simon
3:30 - 4:30 p.m.	Charlotte Newhart, California Chapter of American College of Obstetricians and Gynecologists (formerly with the California Chapter of the American Academy of Pediatrics)
4:30 - 5:00 p.m.	Karen Flannigan, Lead Program, California Department of Health Services

Wednesday, August 4, 1993

9:00 a.m. - 12:00 p.m.	Merced County Health Department
12:00 - 2:00 p.m.	Child's Avenue Clinic
2:00 - 4:00 p.m.	Merced County Department of Human Services

Thursday, August 5, 1993

8:30 - 9:30 a.m.	Contra Costa Health Department
9:30 - 10:30 a.m.	Contra Costa Health Plan
10:30 a.m. - 12:30 p.m.	Contra Costa Department of Social Services
1:30 - 2:30 p.m.	Contra Costa Health Department
3:00 - 4:00 p.m.	Hilltop Pediatrics
4:00 - 5:00 p.m.	Rainbow Pediatrics

Friday, August 6, 1993

9:00 - 10:00 a.m.	Alameda County Department of Social Services
10:00 - 11:30 a.m.	Alameda County CHDP Program
11:30 a.m. - 12 p.m.	Early Intervention Services
12:30 - 3:00 p.m.	Meeting with Providers

II. Georgia

June 14-17, 1993

Monday, June 14, 1993

8:30 - 11:30 a.m.	Georgia Department of Medical Assistance
11:30 a.m. - 12:00 p.m.	CONTINUUM (The "Powerline" Hotline for MCH)
1:30 - 2:30 p.m.	Atlanta Public School System
2:30 - 5:00 p.m.	Department of Human Resources, Division of Public Health
6:00 - 9:00 p.m.	Southwest Community Hospital Primary Care Center, Atlanta

Tuesday, June 15

10:00 - 11:00 a.m.	Meeting with Medicaid Commissioner
1:30 - 3:30 p.m.	Fulton County Health Department, Atlanta

Wednesday, June 16

8:30 - 11:30 a.m.	Lowndes County Health Department, Valdosta
2:00 - 4:30 p.m.	Plains Medical Center, Stuart-Webster Rural Health, Inc., Plains

Thursday, June 17

8:30 - 11:00 a.m.	Bibb County Department of Family and Children Services, Macon
1:00 - 3:15 p.m.	Pediatric Gastroenterologist in private practice, Atlanta

III. Michigan

May 24-28, 1993

Monday, May 24, 1993

9:00 - 10:00 a.m.	Medical Services Administration/Department of Social Services (DSS) -- Program Overview
10:00 - 11:00 a.m.	Medical Services Administration/DSS -- Medicaid Data
11:00 a.m. - 12:00 p.m.	Medical Services Administration/DSS -- EPSDT Policies
1:00 - 5:00 p.m.	Medical Services Administration/DSS -- EPSDT Policies (cont.)

Tuesday, May 25, 1993

10:00 a.m. - 12:30 p.m.	City of Detroit Health Department
1:30 - 3:30 p.m.	OmniCare, Inc., Detroit, MI

Wednesday, May 26, 1993

8:30 - 10:00 a.m.	Bureau of Child and Family Services/Department of Public Health (DPH) -- Program Overview
10:00 a.m. - 12:00 p.m.	Bureau of Child and Family Services/DPH -- EPSDT Policies
12:00 - 2:00 p.m.	Bureau of Policy, Planning, and Evaluation/DPH
2:00 - 2:30 p.m.	Bureau of Child and Family Services/DPH -- EPSDT Policies (cont.)
2:30 - 4:00 p.m.	Michigan Council for Maternal and Child Health

Thursday, May 27, 1993

10:00 a.m. - 12:00 p.m.	Bay County Health Department
1:30 - 4:00 p.m.	Bay Pediatrics

Friday, May 28, 1993

9:00 - 11:00 a.m.	Ingham County Department of Health
11:00 a.m. - 12:00 p.m.	Ingham County Department of Social Services
1:00 - 4:00 p.m.	Medical Services Administration (DSS) and Bureau of Child and Family Services (DPH)

IV. Tennessee

April 5-9, 1993

Monday, April 5, 1993

9:00 - 10:00 a.m.	Bureau of Medicaid/Department of Health (DOH) -- Program Overview
10:00 - 11:00 a.m.	Bureau of Medicaid/DOH -- Medicaid Data
11:00 a.m. - 12:00 p.m.	Bureau of Medicaid/DOH -- Medicaid Quality Control
2:30 - 5:00 p.m.	Bureau of Health Services/DOH -- Local Health and EPSDT

Tuesday, April 6, 1993

8:30 - 10:00 a.m.	Bureau of Medicaid/DOH -- Provider Issues
10:00 - 11:30 a.m.	Department of Human Services -- Medicaid Eligibility/EPSDT Informing
1:00 - 2:00 p.m.	Department of Education -- Part H
2:00 - 3:00 p.m.	Department of Finance and Administration -- The Children's Plan
3:00 - 5:00 p.m.	Bureau of Medicaid/DOH -- General Discussion

Wednesday, April 7, 1993

9:00 - 11:00 a.m.	Perry County Health Department
1:30 - 2:30 p.m.	Tipton County Department of Human Services
2:30 - 5:00 p.m.	Tipton County Department of Health

Thursday, April 8, 1993

9:00 - 10:30 a.m.	Dr. William Terrell, Memphis, TN
10:30 a.m. - 12:30 p.m.	Memphis Health Center
12:30 - 1:30 p.m.	Northside High School -- School Based Clinic
1:30 - 2:30 p.m.	Memphis/Shelby County Department of Human Services
2:30 - 5:00 p.m.	Memphis/Shelby County Department of Health

Friday, April 9, 1993

8:30 - 9:00 a.m.	Nashville/Davidson County Department of Health
9:00 - 10:30 a.m.	Woodbine Primary Care Center
10:30 a.m. - 1:00 p.m.	Sudekum Clinic